DENTAL

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

Patient's Information

Patient Name:_____ Date of birth:_____ Age:_____ Sex:_____
Home Address:_____ City:_____ State:_____ Zip:_____
HomePhone:_____ Bus. Phone:_____ Cell:_____
SocialSecurity No.:_____

Account Information
(Person Financially Responsible for Account)

Name:_____ Social Security No:_____
Relationship to Patient:_____ Date of birth:_____ Age:_____ Sex:_____
Address:_____ State:_____ Zip:_____
Home Phone:_____ Bus. Phone:_____ Cell:_____

Dental Insurance

Primary Carrier
Insurance Company_____ Employer Name:_____
Insured's Name:_____ Date of Birth:_____ Relationship to patient:_____
Insured's Social Security No:_____

Secondary Carrier
Insurance Company_____ Employer Name:_____
Insured's Name:_____ Date of Birth:_____ Relationship to patient:_____
Insured's Social Security No:_____

Emergency Contact

Name:_____ Relationship to Pt:_____ Phone: (____) _____ -_____

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (*name of patient*)_____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purposes of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outline the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates. I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check on my credit history may be made.

Patient Signature:_____ **Date:**_____

Parent/Responsible Party's Signature:_____ **Relationship to Patient:**_____

Patient Name:_____ Date: ____/____/____ Patient DOB: ____/____/____Age: _____

Medical History

Have you been under the care of a medical doctor during the past two years? ..... **Yes** **No**
If Yes, for what? _____
Physician's Name _____ Phone: _____
Have you taken any medications or drugs during the past two years? ..... **Yes** **No**
Are you taking any medication such as aspirin that would be considered a **blood thinner**? ..... **Yes** **No**
Are you taking any bone altering medications? (ex: Boniva, Actonel, Fosamax) ..... **Yes** **No**
Do you have any disease, condition, or problem not listed? ..... **Yes** **No**
Have you ever been told by another physician that you need to take **premedication** before dental treatment? ..... **Yes** **No**
Women (Please Check) ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

AIDS/HIV Positive ..... Y N
Anaphylaxis ..... Y N
Anemia ..... Y N
Arthritis Rheumatism ..... Y N
Artificial Heart Valves ..... Y N
Artificial Joints ..... Y N
Asthma ..... Y N
Atopic (allergy prone) ..... Y N
Autism ..... Y N
Back Problems ..... Y N
Blood Disease ..... Y N
Cancer ..... Y N
Chemical Dependency ..... Y N
Chemotherapy ..... Y N
Circulatory Problems ..... Y N
Cortisone Treatment ..... Y N
Cough Persistant ..... Y N
Cough Up Blood ..... Y N
Diabetes ..... Y N
Epilepsy ..... Y N
Fainting ..... Y N
Food Allergies ..... Y N
Glaucoma ..... Y N
Headaches ..... Y N
Heart Murmur ..... Y N
Heart Problems ..... Y N
Hemophilia ..... Y N
Describe_____
Abnormal Bleeding ..... Y N
Herpes ..... Y N
Hepatitis A/B/C ..... Y N
High Blood Pressure ..... Y N
Jaw Pain ..... Y N
Kidney Disease or Malfunction ..... Y N
Liver Disease ..... Y N
Material Allergies (Latex, Wool, Metal Chemicals) ..... Y N
Mitral Valve Prolapse ..... Y N
Nervous Problems ..... Y N
Pacemaker/ Heart Surgery ..... Y N
Psychiatric Care ..... Y N
Rapid Weight gain/loss ..... Y N
Radiation Treatment ..... Y N
Respiratory Disease ..... Y N
Rhuematic/Scarlet Fever .... Y N
Shingles ..... Y N
Shortness of Breath ..... Y N
Skin Rash ..... Y N
Spina Bifida ..... Y N
Stroke ..... Y N
Surgical Implant ..... Y N
Swelling of Feet or Ankles ..... Y N
Thyroid Disease or Malfunction ..... Y N
Tobacco Habit ..... Y N
Tonsillitis ..... Y N
Tuberculosis ..... Y N
Ulcer/Colitis ..... Y N
Venereal Disease ..... Y N

Are you currently taking any medications? Yes_____ No_____

_____

_____

*If you are taking more than 4 medications, please provide a seperate list.

Medical concerns other than listed above._____

_____

Are you allergic to any medications? Y N
If so please list below.

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____/_____/_____

Dr. Signature: _____

Medical History Review

Patient Signature:					
Date:					
Doctor Signature:					